DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKERS COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011
(202) 576-6265

Date of This Report

Employee Social Security Number

Employer Identification Number

Insurer Number

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

EMPLOYEE'S CLAIM APPLICATION

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYER/INSURER

A CLAIM FOR WORKERS COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS, WILL SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOUR INSURER IMMEDIATELY.

Date and Time of Injury _____ **am/pm? Office Representative**
Place where injury occurred:
Description of Injury:

THIS IS TO NOTIFY YOU

Employer

That while in the employ of the above named employer I sustained a disabling injury 9 **or contracted an occupational disease** 9 **as described above. The disability was caused by**:

Treating Physicians Name and Address

YOU SHOULD HAVE ALREADY FILED OR SHOULD FILE EMPLOYEES NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THIS CLAIM WITH THE OFFICE OF WORKERS COMPENSATION.

_____
(Employee's Signature)